

**STATE OF MAINE
DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES
MENTAL RETARDATION SERVICES**

**APPLICATION FOR CERTIFICATION
AS PROVIDER OF SECTION 13.05, TARGETED CASE MANAGEMENT SERVICES**

DATE: _____

NAME OF APPLICANT AGENCY: _____

PHYSICAL ADDRESS:

MAILING ADDRESS: (if different)

CORPORATION NAME/ADDRESS (if different): _____

COUNTY _____

SOCIAL SECURITY # OR EMPLOYER ID #: _____

NAME/TITLE OF PROGRAM ADMINISTRATOR _____

PHONE # _____ FAX # _____ EMAIL _____

NAME OF CONTACT PERSON: _____

PHONE # _____ FAX # _____ EMAIL _____

NAME OF CHIEF ADMINISTRATIVE OFFICER: _____

I/We have received and read the rules for the certification process. I/We have attached copies of all material required to demonstrate compliance with the certification application process. I/We understand that certification is necessary to become an approved provider of services under MaineCare Manual Section 13.05 (10-144 CMR Ch 101, Section 13). I/We understand that this application authorizes representatives of the Department of Behavioral and Developmental Services and the State Fire Marshal's Office (if applicable) to make such visits and inspections as may be necessary to ensure that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department of Behavioral and Developmental Services to obtain any criminal or protective records information which may be on file in any Country, State or Federal Office.

I/We further certify that all information contained in this application is complete and accurate.

SIGNATURES REQUIRED:

Applicant/Operator/Administrator

DATE: _____

Type or Print Name

2ND Applicant (If Applicable)

DATE: _____

Type or Print Name

Board President (If Applicable)

DATE: _____

Type or Print Name

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FOR BDS USE ONLY

APPLICATION RECEIVED _____

INITIAL REVIEW BY _____
NAME DATE

NOTE REQUESTS FOR ADDITIONAL INFORMATION ON SEPARATE SHEET AND ATTACH TO THIS APPLICATION. DESCRIBE INFORMATION REQUESTED AND DATE REQUESTED, REASON, PERSON AND DATE CONTACTED, RESPONSE.

POLICIES REVIEWED AND APPROVED BY _____
NAME DATE

CERTIFICATION GRANTED _____
DATE

SIGNATURE OF BDS REPRESENTATIVE _____